2016
Implementation Strategy Report
for Community Health Needs

Southwest General Health Center, Middleburg Heights, OH

Community Health Needs Assessment Implementation Strategy

Southwest General Health Center, a 358-bed hospital located in Middleburg Heights, Ohio, conducted a comprehensive Community Health Needs Assessment (CHNA) beginning in February 2016. Southwest General Health Center is a non-profit hospital serving southwestern Cuyahoga, northern Medina and eastern Lorain counties. Founded in 1920 by residents of the surrounding communities, Southwest General has a rich history of community partnership and a deep commitment to the health and wellbeing of its residents.

With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals require community health needs assessments and implementation strategies, which are approaches and plans to actively improve the health of communities

served by health systems. These strategies provide hospitals and health systems with the information they need to deliver community benefits that can be targeted to address the specific needs of their communities. Through coordination and community development initiatives that are based upon the outcomes of the CHNA, Southwest General Health Center is implementing strategies to address identified health needs and to impact the health of the community they serve.

To adhere to the requirements imposed by the IRS, tax-exempt hospitals and health systems must:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA.

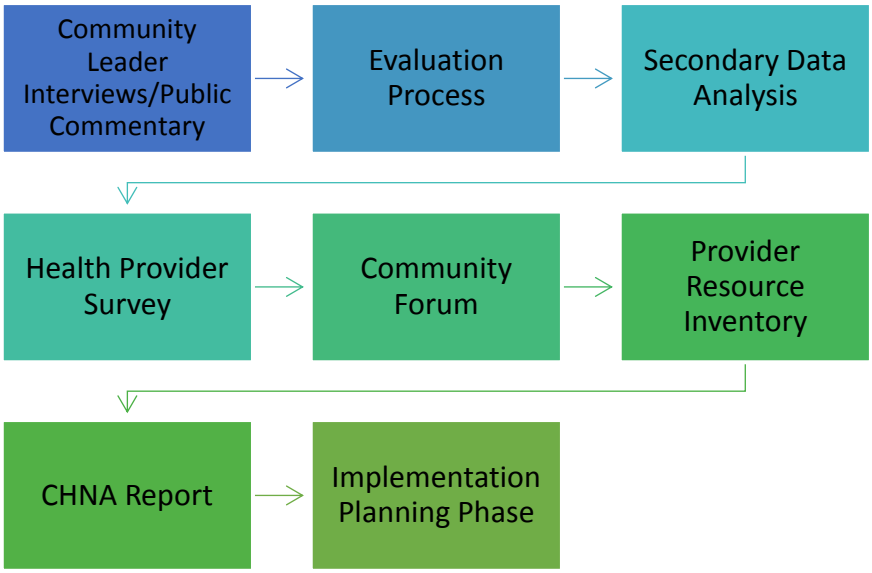
Community Health Needs Assessment Process

The CHNA process was facilitated by Tripp Umbach and an internal working group of hospital leaders and included extensive input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues, data related to underserved and vulnerable populations, and representatives of vulnerable populations served by the hospital.

The comprehensive CHNA identified and prioritized community health needs. The project component pieces involved to determine the community health needs included (see Figure 1):

- Community leader interviews,
- Public commentary on the previous CHNA and implementation plan,
- Evaluation of implementation strategies from the 2013 CHNA,
- Secondary data analysis of health status and socioeconomic environmental factors related to health and well-being of residents,
- Health provider survey,
- Community forum at Southwest General Health Center,
- A provider inventory of programs and services related to key prioritized needs.

Figure 1: CHNA Process



The final CHNA report was developed based on data collection findings and prioritization of community health needs. Additional information regarding each component of the project, and the results, can be found in the full CHNA report.

Southwest General Health Center used the CHNA findings to develop goals and strategies designed to address local health care concerns and will work with regional and community organizations to improve the health status of the community Southwest General Health Center serves.

The CHNA report and the Implementation Strategy Plan fulfill the IRS requirements on tax-exempt hospitals and health systems.

Addressing Identified Health Issues and Needs

According to the World Health Organization (WHO), health is more than the absence of disease. The health status of a community depends on many factors, including quality of health care, social and economic determinants, individual behaviors, heredity, education and the physical environment. Communities across the U.S. face numerous challenges and issues that negatively affect the overall health status of residents and hinder growth and development.

In the Southwest General study area, three key community health issues and needs were identified:

- Improving Chronic Disease Management
- Cardiovascular Health (Obesity & Healthy Choices)
- Behavioral Health (Mental Health & Substance Abuse)

Within each of the community health need areas, multiple factors must be considered. Health behaviors, education, and socioeconomic/environmental conditions greatly affect an individual's health status and their ability to overcome disease and other health issues. It is critical for health providers and community-based organizations to understand the regional health issues and be aware of what services and improvements are most needed.

The CHNA represented a comprehensive community-wide process which connected community residents, health institutions, religious organizations, and human service agencies together to evaluate the community's health and social needs. The development of the 2016 implementation strategy plan used results from the previous CHNA along with results from the 2016 CHNA needs. Southwest General Health Center understands the importance of continuing to build upon the previous implementation efforts in order to capitalize and strengthen existing programs within the organization. With the completion of two CHNA cycles and the importance of building upon the previous work Southwest General has implemented, the 2016 implementation strategy plan focuses on the combined needs of both assessment periods. These results are depicted in the below table (See Table 1).

It important to note that in-depth discussions and feedback collected from Senior Management and working group members, fine-tuned and adjusted the 2012/21013 and 2016 CHNA needs into the current combined needs; which are represented in the implementation strategy plan.

The efforts and hard work of the working group along with Senior Management through the implementation strategy plan continue to highlight the health center's mission and vision ensuring the core values of proving excellence in care and individual patient attention.

Table 1: Combined CHNA needs from 2012/2013 and 2016

2012/2013 CHNA Needs	2016 CHNA Needs	Combined Needs
1. Cardiovascular Health 2. Mental Health & Chemical Dependency 3. Cancer 4. Prescription Assistance	1. Chronic Disease Management • Education • Socioeconomic Barriers to Care • Resource Awareness/ Patient Navigation • Transportation 2. Obesity & Healthy Choices • Nutrition • Physical Activity • Access and Use of Primary Care 3. Behavioral Health • Mental Health • Substance Abuse	1. Improving Chronic Disease Management 2. Cardiovascular Health (Obesity & Healthy Choices) 3. Behavioral Health (Mental Health & Substance Abuse)

Community Health Need Not Addressed by Southwest General Health Center and Why

It is important to note that Southwest General Health Center completed implementation efforts for the prescription assistance program during the previous CHNA cycle. The prescription assistance program continues to be available for patients who have difficulties paying for medication.

Priority #1

Improving Chronic Disease Management

Chronic diseases are typically defined as long-term diseases or conditions that require ongoing medical attention and have the ability to limit an individual's daily activities. As stated by the Centers for Disease Control and Prevention, chronic diseases and conditions—such as heart disease, stroke (risk of), cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems.[1] Health risk behaviors are unhealthy behaviors which can be changed. Health risk behaviors such as lack of physical activity, poor nutrition, tobacco use, and drinking too much alcohol—cause much of the illness, suffering, and early death related to chronic diseases and conditions.[2]

Chronic diseases currently account for most deaths in the United States and globally. As of 2012, about half of all adults in the United States—117 million people—had one or more chronic health conditions. One in four adults had two or more chronic health conditions.[3] Chronic diseases are responsible for seven out of every 10 deaths each year, and treating people with chronic diseases accounts for 86 percent of our nation's health care costs.[4]

Chronic disease management is an integrated care approach in managing chronic illnesses which includes screenings, check-ups, monitoring and coordinating treatment, and patient education.[5] It is the aftermath and recovery efforts which make it more difficult for patients to resume an active and productive lifestyle with proper treatment efforts. Chronic disease management in the state of Ohio should be a high priority focus area as the Health Policy Institute of Ohio (HPIO) ranked the state 40 out of the 51 states (including the District of Columbia) in the U.S. on a composite measure of public health in 2014. This public health ranking is based upon Ohio's overall health and wellbeing, health behaviors, and conditions and diseases.

As it relates to chronic diseases, Ohio ranks among the worst in the country for cancer deaths (41st), cardiovascular deaths (37th), and diabetes rate (45th).[6] According to 2012 data from the Ohio Behavioral Risk Factor Surveillance System, Ohioans age 18 and older had a higher prevalence of coronary heart disease (5.4 percent), stroke (3.1 percent), diabetes (11.7 percent), cancer (6.6 percent), chronic obstructive pulmonary disease (COPD) (8.6 percent) and arthritis

[1] Centers for Disease Control and Prevention. Chronic Disease Overview. http://www.cdc.gov/chronicdisease/overview/.
[2] Ibid.
[3] Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. Prev Chronic Dis. 2014;11:130389. DOI:http://dx.doi.org/10.5888/pcd11.130389
[4] Centers for Disease Control and Prevention. Preventing Chronic Disease. http://www.cdc.gov/chronicdisease/about/prevention.htm
[5] Chronic Disease Management. https://www.healthcare.gov/glossary/chronic-disease-management/. 2016.
[6] United Health Foundation, America's Health Rankings 2013 – State Data: Ohio [Online]. Retrieved from http://www.americashealthrankings.org/OH. Last accessed 9/17/2014.

(30.0 percent) compared to U.S. adults.[7] It is no surprise that 62 percent of deaths in the state of Ohio can be attributed to chronic diseases, making it the leading cause of death in the state.[8]

As identified by the Ohio Department of Health, the state is experiencing increased rates of chronic illness due to the following behavioral risk factors: tobacco use, physical inactivity, poor nutrition, and alcohol use. As chronic diseases and risk factors of chronic disease are a concern, the state is taking measures to address the issue. In 2014, Ohio released a new chronic disease state plan, Ohio's Plan to Prevent and Reduce Chronic Disease: 2014-2018 (Chronic Disease Plan).

This plan aims to address chronic disease in Ohio through the policies, systems, and environments that influence chronic disease outcomes and health behavior change. The four (4) approaches are:

1. Environmental Approaches - Making healthy behaviors easy and convenient for all Ohioans.
2. Health System Interventions - Improving the delivery and use of healthcare services in order to prevent disease, detect diseases earlier, and manage risk factors.
3. Community-Clinical Linkages - Ensuring those with or at high risk for chronic diseases have access to community resources in order to best manage their disease or risk factors.
4. Data and Surveillance - Providing data to inform, prioritize, deliver and monitor programs and population health.

The Southwest General study area also warrants concern when it comes to high rates of chronic disease. The study area experiences similar rates of chronic health conditions as the state of Ohio, and in some instances, the study area has higher rates of chronic disease than the state.

According to the health provider survey, the most pressing health problems in the community are heart disease and stroke (42.9 percent), obesity (38.1 percent), and diabetes (33.3 percent). In order to properly prevent and manage chronic diseases, a strategic emphasis on education, understanding socioeconomic barriers, increasing resource awareness and patient navigation, as well as providing solutions for transportation, will play a large part in the prevention and management of the diseases.

Education

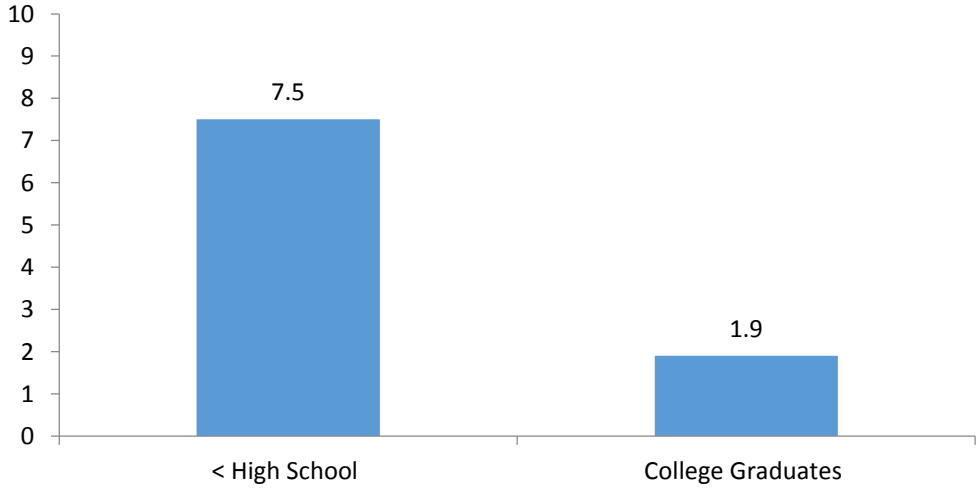
Health education is the first step in helping individuals and families lead a healthy lifestyle and to properly manage their chronic health conditions. While it is known that education can lead to better jobs and higher incomes, notable studies show that better-educated individuals live longer, healthier lives than those with less education, and their children are more likely to thrive. A study performed by the Robert Wood Johnson Foundation shows that an additional

[7] . 2012 Ohio Behavioral Risk Factor Surveillance System. Ohio Department of Health. 2014.
[8] Ohio Bureau of Vital Statistic. Ohio Department of Health. 2014.

four years of education reduces a range of health risks and leads to decreased risk of heart disease by 2.2 percent, diabetes by 1.3 percent, and obesity by 5 percent.[9]

The Ohio 2013 Behavioral Risk Factor Surveillance System (BRFSS) Annual Report put forth by the Ohio Department of Health provides indicators that show a connection between education and health conditions. The report examines the rate of chronic conditions by the level of educational attainment of the population. In Ohio, the stroke incidence rate decreases as the level of educational attainment increases.

Figure 2: Stroke by Education Breakout



Source: Ohio Behavioral Risk Factor Surveillance System

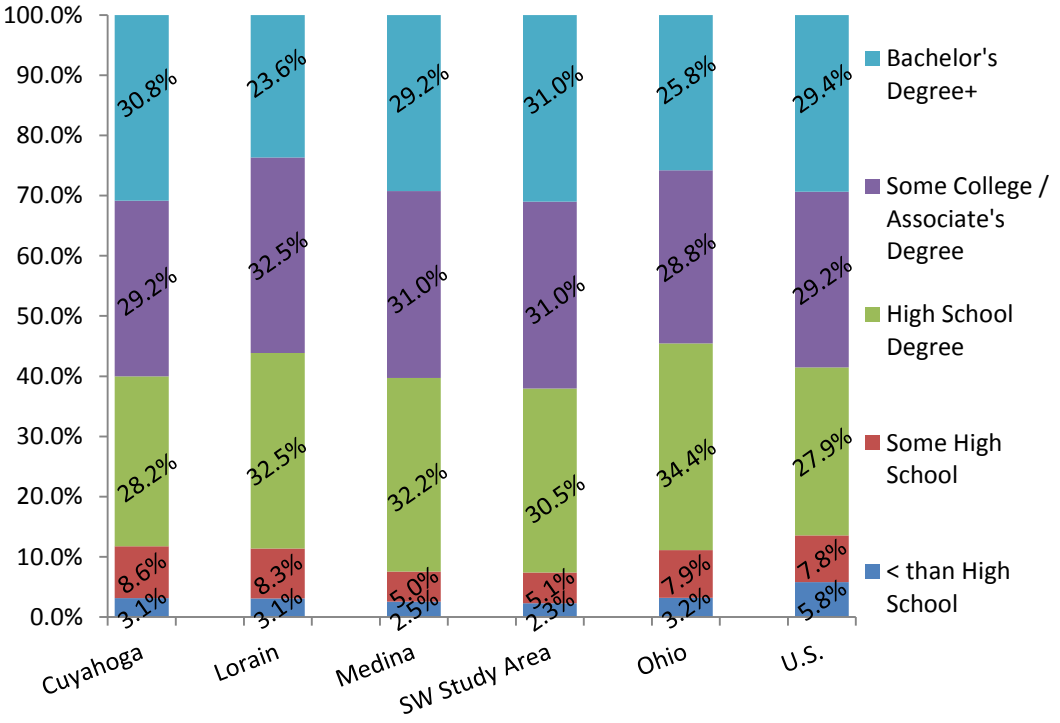
According to the BRFSS, 7.5 percent of adults with less than a high school education have had a stroke, compared with 1.9 percent of college graduates.[10] The prevalence of heart disease, high blood pressure, and high cholesterol also follows the same trend for the residents of Ohio, decreasing in prevalence as education level increases.

These data provide a snapshot of the effect education can have on a person's health status. Community leaders in the study area also recognize the connection between education and health status, as participants cited health education as a key component to managing health conditions and leading a healthy life. Secondary data results further demonstrate the connection between education, specifically education that focuses on an individual's health, and health outcomes.

[9] "F as in Fat: How Obesity Threatens America's Future." Trust for America's Health. http://healthyamericans.org/assets/files/TFAH2012FasInFat18.pdf. 2012.
[10] Ohio Behavioral Risk Factor Surveillance System, Ohio Department of Health, 2013.

Looking broadly at overall education, Lorain County has the lowest percentage of residents with a bachelor's degree or greater (23.6 percent), (See Figure 3).[11,12] At the same time, Lorain County has the highest rates of obesity (a top chronic disease risk factor), high blood pressure, asthma, lung disease, and lung cancer in the study area.

Figure 3: Educational Attainment[13]



Source: Truven Health Analytics

While Lorain County is worst in the study area in terms of having a high rate of several chronic diseases, residents in Cuyahoga County also experience a number of chronic health issues. However, in contrast to the education levels of the residents in Lorain County, Cuyahoga represents an overall well-educated population, with a large percentage of residents having bachelor's degree or greater. Although Cuyahoga County has an overall well-educated population, the region experiences higher rates of the following chronic conditions in comparison to the other counties in the Southwest General study area:

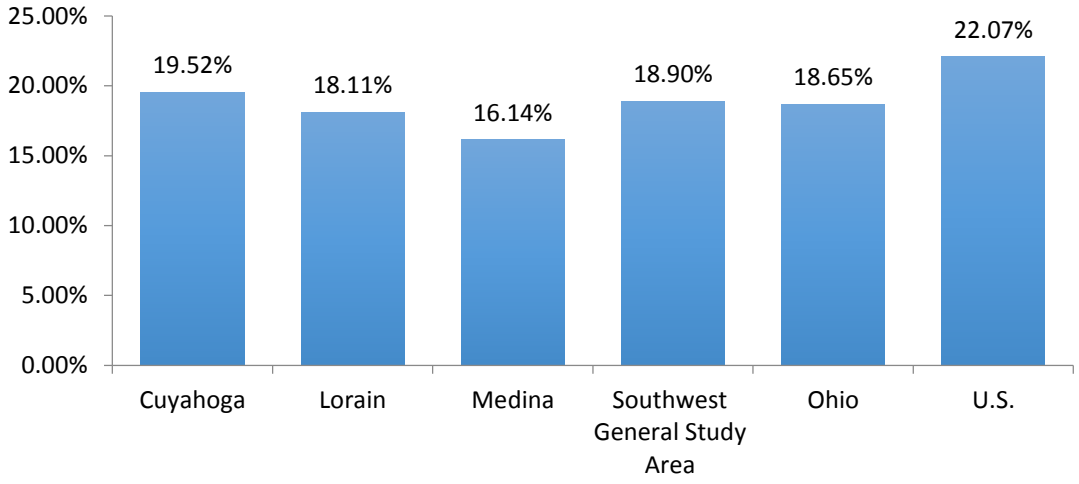
- Diabetes (10.0 percent)
- High Cholesterol (38.3 percent)

[11] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, 2012 via Community Commons.
[12] Truven Health Analytics. 2016.
[13] For education levels, the "Southwest General Study Area" includes only the ten ZIP code areas.

- Cancer – Breast, Colon, and Prostate (130.5 per 100,000 population; 43.8 per 100,000 population; and 151.1 per 100,000 population, respectively)
- Mortality Due to Cancer (188.2 per 100,000 population)
- Mortality Due to Heart Disease (205.8 per 100,000 population)

The high rates of chronic conditions in Cuyahoga County may be attributable to a lack of proper health education. This leaves the population unable to understand the steps they need to take to lead a healthy life and alleviate their risk of developing chronic conditions. One important step to maintaining a healthy lifestyle and receiving necessary health education is having a consistent source of care. Having a regular doctor or consistent source of care allows patients to gain a better understanding of their health conditions and take proper steps toward managing their health. In Cuyahoga County, a higher percentage of residents fail to have a consistent doctor or source of primary care in comparison to the other counties in the study area, as 19.5 percent of the population does not have a regular doctor (See Figure 4).[14]

Figure 4: Percent Adults without Any Regular Doctor



Source: Centers for Disease Control and Prevention

By failing to have a regular doctor and source of health care, residents within Cuyahoga County may not understand the value of preventative measures which limit chronic diseases, such as exercise and proper nutrition. For example, community forum participants explained that even if individuals understand the value of healthy behaviors such as exercise and proper nutrition, the consistent and specific education regarding these health behaviors, such as what to eat, how

[14] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. Additional data analysis by CARES,. 2011-12. 2012 via Community Commons.

much to eat, and how much to exercise is necessary for residents to take proper steps in the prevention and management of chronic health conditions.

The community leaders that were interviewed reached consensus on the necessity of providing frequent and consistent nutritional education, outreach, and community intervention to help combat risk factors that lead to the high rate of chronic diseases throughout the Southwest General Health Center study area, as well as to help patients who currently struggle with a chronic disease to take the proper steps to manage their conditions. Community leaders also noted the importance of collaboration among hospitals, schools, and local organizations to provide health educational tools.

With Cuyahoga County being worst in the study area, the state of Ohio, and the nation in heart disease, breast cancer, colon cancer, and prostate cancer, it is clear that a focus on health education is needed for residents in this county. Strategies to employ effective health education should be implemented throughout the study area, with specific focus in Lorain and Cuyahoga counties, to improve residents' ability to alleviate the risk of developing, as well as to manage, chronic conditions.

The CHNA noted that residents in Cuyahoga County face a number of socioeconomic challenges and barriers to receiving the care necessary to manage their health conditions. Improved coordination and outreach provided through community nurses will serve to improve access to care. The community nurses will continue to educate the broader community and underserved populations on available health services, programs and resources designed to help them better manage their chronic diseases.

In the absence of readily available health care services and providers, Telehealth can be an effective strategy and tool for patient evaluation and facilitating access to care for patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). The use of Telehealth expedites patient care and helps ensure appropriate patient disposition for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) patients and families.

The following goals and strategies address improving access to care and community outreach:

GOAL 1:

Improve access to care through community education and outreach efforts.

Strategy 1: Coordinate outreach activities to connect patients with identified needs.

Action 1a.

Continue telephonic services such as 877-SWG-BEAT and Health Connection features. 877-SWG-BEAT and Health Connection are vehicles that serve to link patients and the community with health information. Approximately 8,500 telephonic calls are placed annually through these services. The services improve communication and outreach to community patients and families.

Action 1b.

Optimize community awareness through print publications, social media, website, and printed collateral materials for various programs and services. The health system has a wealth of knowledge and resources available to assist patients and families. However, many community residents as well as providers may not be aware of what services and programs are available. Increasing outreach through these platforms is an effective means to link patients to available resources and health education.

Action 1c.

Link patients and families to community and health system resources. A plethora of community and health system services are available and designed to assist patients in managing their health and well-being and to empower patients to become partners in their care.

Strategy 2: Apply TeleHealth to assist patients in managing their Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF).

Socioeconomic Barriers to Care

Socioeconomics play a large role in an individual's ability to receive health care and understand his or her health needs. As it relates to chronic health disease management, which requires ongoing care and many preventative measures, socioeconomic barriers can pose a challenge to effectively manage health conditions. In addition to education, other social and economic

factors that can play a role in managing one's health are employment, income, poverty, and crime.

Socioeconomic conditions and an individual's ability to receive health care and manage health conditions are oftentimes interrelated. For example, an employed individual with a steady income has a greater ability to obtain insurance and receive health care screenings that allow for the management of chronic conditions.

The 2016 County Health Rankings report ranks the counties in the state of Ohio in terms of a number of categories that provide a picture of the overall health status of a county and its residents, including social and economic factors. In terms of social and economic factors, Cuyahoga County ranks the worst in the study area, with a ranking of 79 out of 88 counties. Lorain County ranks 52 out of 88, while Medina County fares very well in the Social & Economic Factors category with a ranking of seven out of 88. The Social & Economic factors category is determined by inputs such as the level of educational attainment, unemployment rate, level of poverty, income inequality, and rate of violent crime (See Table 1).

Table 1: Ohio County Health Rankings 2016

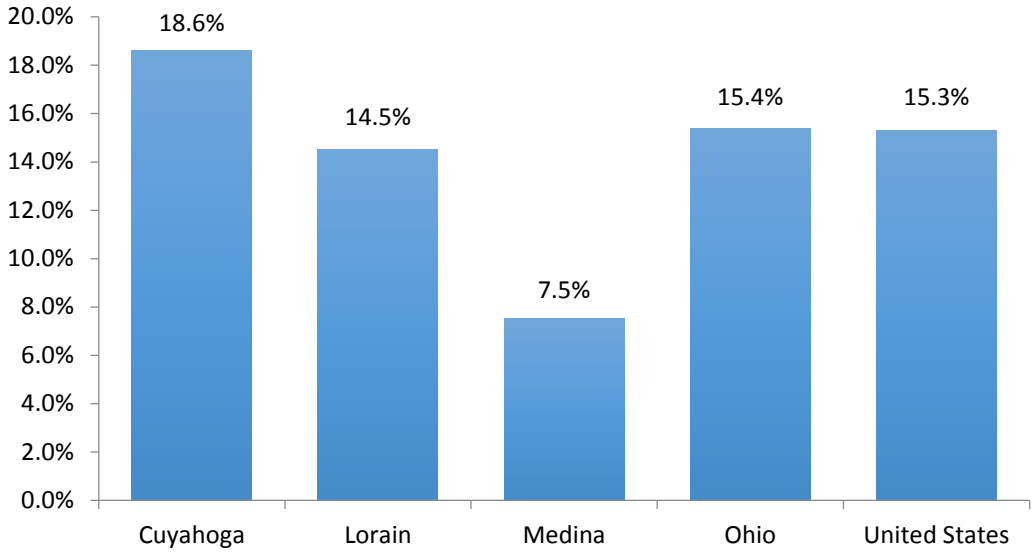
Ohio (Rankings out of 88)	Social & Economic Factors 2016
Cuyahoga	79
Lorain	52
Medina	7

Source: County Health Rankings, Ohio Health County Rankings 2016

Unemployment, income, and poverty are important socioeconomic factors in accessing health, as individuals who are unemployed and living in poverty may lack insurance and are unable to pay out-of-pocket health service costs. While the state of Ohio has enacted Medicaid expansion, which gives more underserved residents the ability to obtain health insurance, it can still be increasingly difficult for residents who are not financially well off to access health care coverage and treatment to manage their chronic conditions. Currently, Cuyahoga County has the highest percentage of residents living below 100 percent of the Federal Poverty Level (18.6 percent) (see Figure 5) in the study area; this percentage is also higher than the state and the nation.[15]

[15] US Census Bureau, American Community Survey, 2010-14.

Figure 5. Percentage of Population living in Poverty



Source: US Census Bureau, American Community Survey

Poor and inadequate housing conditions also serve as a barrier to properly managing chronic health conditions. Having a safe, clean, and healthy housing environment is important to an individual's daily health. The housing market in the Cleveland area is still sluggish, despite slight improvements since the recession. Housing prices and housing vacancies are both issues for Cleveland families today. "Census data tell us the average American has the majority of their net worth tied up in the equity of their home," said Jim Rokakis, a former Cuyahoga County treasurer. Residents who have finances tied up in housing may not want to spend additional monies on health care.[16]

Housing issues are prominent in Cuyahoga County, and may have a link to the health status of the county. Cuyahoga County reports the highest rate of HUD-Assisted housing units (633 per 10,000 housing units), overcrowded housing (1.47 percent), substandard housing (35.4 percent), and vacant housing (13.7 percent) out of the counties in the Southwest General Health Center study area.[17]

Community leaders emphasized the importance of communicating what resources and services are available to the region. A comprehensive provider inventory, which is consistently maintained as the health care landscape continues to change, would allow community members an understanding of available services and allow providers an understanding of available referral locations.

[16] Jarboe, Michelle. "Cleveland-area house prices are rising, but recovery is uneven at best." March 21, 2016. http://www.cleveland.com/business/index.ssf/2016/03/cleveland-area_house_prices_ar.html
[17] US Department of Housing and Urban Development, 2015 via Community Commons.

In developing an implementation strategy to improve chronic disease management across the community, it is imperative to continue to emphasize the significance of poor socioeconomic conditions and the need for health education necessary to assist community residents in taking greater control of their health through accessing available health resources.

Photo 1: Van Transportation Program

Community leaders and health providers recognized the impact of socioeconomic factors as a barrier in accessing health care, medical treatments and limiting the ability of patients to manage their health conditions. The health provider survey respondents reported the following socioeconomic factors as the top three barriers to accessing care in the community: 1) high out of pocket costs/high deductibles (72.7 percent); 2) no insurance coverage (68.1 percent); and 3) transportation (13.8 percent).

Convenient and available transportation may not be available to assist patients in obtaining proper health screenings and accessing medical care. Expanding the geographic location of community-based health screenings serves to broaden service provisions and allows for the early detection and prevention of disease. Conducting health screenings across geographic areas helps target populations with greater health needs, such as the elderly, disabled, and low income residents.

Health Risk Behaviors are defined as unhealthy behaviors which can be changed. Health risk behaviors such as a lack of physical activity, poor nutrition or lack of exercise, alcohol use, and smoking are factors related to the occurrence of chronic diseases and conditions.[18]

The following goals and strategies address socioeconomic barriers:

GOAL 2:

Expand preventative services through community outreach efforts.

Strategy 1: Expand geographic locations to provide community-based health screenings.

Strategy 2: Work with primary care physicians and staff to assist patients in accessing health education and available services.

[18] Ibid.

Efforts to link high risk patients and families to community and health system resources serve to enhance the quality of care and strengthen provider-patient communication. The complexity of health needs presented by high risk and chronically ill patients can be identified as health system staff and primary care offices work together to connect patients to health education and internal and external services and support systems that meet those needs.

Priority 2:

Cardiovascular Health

Obesity

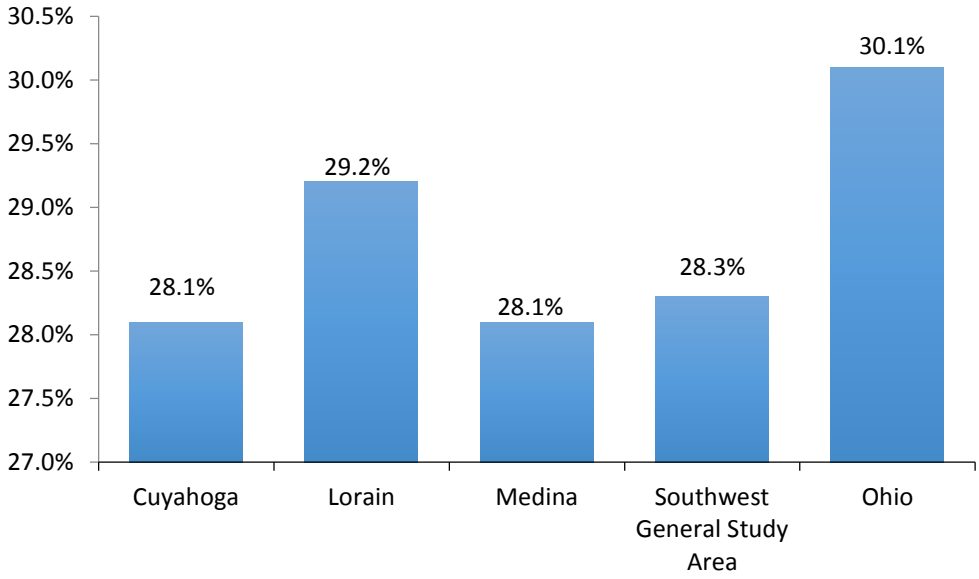
Obesity is a major health issue that affects residents in communities across the U.S. More than one-third (37.7 percent) of adults in the U.S. are obese, and the rate of obesity has more than doubled since the 1970s.[19] Adults are not the only ones affected by obesity, as one in six children and adolescents in the U.S. are obese.[20] Obesity is also a prevalent issue in the state of Ohio; the state had the eighth highest obesity rate in the nation in 2014 with 32.6 percent of the population being obese.[21] Obesity (or Body Mass Index of 30 or over) is a particularly concerning issue because of the health problems and chronic diseases that often stem from obesity. The high rates of obesity in Ohio translate into high rates of obesity-related health problems, as the state ranked ninth in the nation for diabetes and 17th in the nation for hypertension.[22]

Obesity is deemed as a particularly concerning issue among community leaders and health providers in the Southwest General study area. During community leader interviews and the community forum, participants cited obesity as a top heath issue in the community. Furthermore, surveyed health providers listed obesity as one of the three most pressing health concerns for the community. In the previous 2013 CHNA study, adult weight status was also examined as a health concern.

[19] "Obesity in the U.S." Food Research and Action Center. http://frac.org/initiatives/hunger-and-obesity/obesity-in-the-us/. 2016.
[20] "Obesity in the U.S." Food Research and Action Center. http://frac.org/initiatives/hunger-and-obesity/obesity-in-the-us/. 2016.
[21] "The State of Obesity in Ohio." The State of Obesity. http://stateofobesity.org/states/oh/. 2015.
[22] "The State of Obesity in Ohio." The State of Obesity. http://stateofobesity.org/states/oh/. 2015.

The study area overall had a lower percentage of obese residents (28.3 percent) in comparison to the state of Ohio (30.1 percent) in 2012, however, obesity rates are still high in the study area and considered a major community health need (See Figure 6). The CHNA noted that Lorain County has the highest percentage of obese adults (29.2 percent) in comparison to Cuyahoga and Medina counties. This percentage is slightly below the percent of obese adults in the state.

Figure 6: Percent Obese Adults



Source: Centers for Disease Control and Prevention

Community leaders and health providers tend to view obesity as a top health need in the region due to the chronic diseases that stem from obesity. This is evidenced by the CHNA, which documented higher rates of heart disease and high mortality due to heart disease, and stroke as compared to state and national rates.[23] Cardiovascular disease is among the chronic diseases cited as a top concern.

Healthy Choices

Both community leaders and health providers cited poor nutrition and poor eating habits as risk factors for obesity among residents in the community. Healthy People 2020, a national promotional and disease prevention initiative, examines the importance of a healthy diet in combatting obesity and promoting general health. The Healthy People 2020 goals encourage healthy diets through the development of a healthy eating plan, which includes the consumption of whole grains, fresh fruits and vegetables, low-fat or fat-free dairy, and lean

[23] Centers for Disease Control and Prevention. National Vital Statistics System. 2009-2013.

meat, while at the same time limiting the intake of saturated and trans fats, cholesterol, sugars, and sodium.[24]

As set forth in the nutritional plan from Healthy People 2020, fruit and vegetable consumption is an important component of having a well-balanced diet. Unfortunately, proper fruit and vegetable consumption is lacking in the state of Ohio. Across the state of Ohio, 41.6 percent of residents cited consuming fruit less than one time day and 26.3 percent of adults cited consuming vegetables less than once daily.[25] Fruit and vegetable consumption is also lacking in the study area. Approximately 76.2 percent of residents in the study area have inadequate fruit/vegetable consumption, which is higher than the percentage across the U.S. (75.7 percent).[26]

The CHNA Implementation Strategy takes steps to alleviate the risk of cardiovascular disease by emphasizing the importance of health screenings and addressing obesity, nutrition and physical activity.

Strategies to address cardiovascular health focus on proper nutrition, which includes eating fresh fruits and vegetables, physical activity, and receiving consistent care from a primary care provider. This focus can help to reduce the risk of obesity and cardiovascular disease. Working in collaboration with schools to develop programs that promote healthy choices and emphasize the importance of health behaviors such as physical activity can help combat obesity among youth and reduce the risk of chronic disease in the future.

In collaboration with long standing community partner organizations such as the American Heart Association, the American Stroke Society, the American Cancer Society, SW General will host a number of walks, runs and community parades to encourage broad community participation in physical activity initiatives.

[24] "Nutrition and Weight Status." Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status.2014.
[25] "Ohio: State Nutrition, Physical Activity, and Obesity Profile." National Center for Chronic Disease Prevention and Health Promotion. 2015.
[26] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. 2005-2009. Accessed via Community Commons. Adequate fruit consumption is defined as five or more servings of fruits and vegetables a day.

Health education will be provided at targeted churches and senior centers to improve nutrition and physical activity among adults and seniors. Many adults and seniors present comorbid chronic diseases, which is the presence of one or more chronic diseases or disorders. Health information and education on healthy eating and practices helps patients better manage their cardiovascular disease as well as comorbid diseases such as Chronic Obstructive Pulmonary Disease (COPD), high blood pressure, high cholesterol, and Type 2 diabetes.

With a high incidence of cardiovascular disease across the study area, efforts to provide early detection, treatment and prevention of cardiovascular disease are critical.

To address healthy behaviors among adults and adolescents, the health system will explore ways to increase employee participation in available fitness programs. Strategies that improve healthy behaviors among employees will reduce the risk factors as well as the incidence of cardiovascular disease.

The following goals and strategies address cardiovascular health barriers:

GOAL 1:

Collaborate with schools to improve nutrition and physical activity.

Strategy 1: Collaborate with local schools to create school activity programs with SW General.

GOAL 2:

Improve the overall well-being of community residents.

Strategy 1: Promote organized activities with national and regional programs that encourage physical activity.

Strategy 2: Expand education efforts on healthy eating and practices to churches, and senior communities.

Strategy 3: Promote annual cardiovascular health specific screening programs: Healthy Heart, Grey Matters, Circulation Circuit.

Strategy 4: Expand hospital efforts to increase employee participation in fitness programs.

Strategy 5: Continue outpatient based clinics for Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).

Southwest General has developed a plethora of outpatient clinics designed to address very specific health needs and to help patients lead healthier lives. The outpatient based Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) clinics have served over 100 patients annually.[27] The clinics provide education to patients and family members to reduce hospital admissions and make certain patients have the appropriate tools and services necessary to remain healthy.

Photo 2: 2016 Old Oak Run

[27] The outpatient CHF and COPD clinics are still in its infancy stages. It is the vision of Southwest General that the number of patients served annually will increase.

Priority 3:

Behavioral Health

Behavioral Health

Behavioral health, which includes mental health and substance abuse, affects families and individuals across the nation as well as the Northeast Ohio region. An increasing number of individuals are being diagnosed with mental illness or with substance abuse issues. Genetics and socioeconomic factors such as poverty, alcohol and substance use increase the likelihood of individuals developing a mental health problem.

Untreated behavioral health issues can result in substantial social and economic costs. Individuals with untreated mental illness and substance abuse issues are more likely to experience joblessness, homelessness and incarceration, creating a devastating cycle of poor health, instability and crisis.

Mental Health

Mental illness affects people of all ages, ethnicities and socio-economic backgrounds. In 2014, the National Institute of Mental Health reported that 18.1% or 9.8 million adults age 18 and older have a mental illness. This stark statistic represents 4.2% of all Americans. The report notes that 1 out of every 25 adults need both mental health and substance use disorder treatment and 68% of adults with mental illness or substance use disorders also have one or more chronic medical conditions.

According to the American Hospital Association, one in four Americans experiences a mental illness or substance abuse disorder each year, and the majority also has comorbid physical health conditions.[28]

Mental health treatment and support services assist individuals and families to live with their mental illness and to lead productive lives. Southwest General mental health services include adult and geriatric inpatient units, an emergency intake and assessment team positioned in the ED, a Partial Hospitalization Program (PHP), as well as an Intensive Outpatient Program (IOP) for adults.

To improve continuity and access to care for adolescents, psychiatrists provide ambulatory 1:1 individual counseling services. These comprehensive mental health services support the physical health, emotional health and well-being

[28] American Hospital Association: http://www.aha.org/advocacy-issues/initiatives/behavioral/index.shtml

for individuals and families affected by mental health disorders.

Just over 20 percent of children (1 in 5) in the U.S. were reported to have a serious mental health condition[29]. Providing informational programs to local school students regarding mental health and substance abuse helps improve access to behavioral health services and lays a foundation for prevention, early intervention, treatment and recovery.

Those who have experienced mental illness and/or substance abuse can be trained to help inform others on how to live with their condition, to follow treatment regimens and to improve their lifestyles.

A formal partnership with a mental health agency can serve to add clinical services and social supports that meet the complexity of needs for individuals and families with mental health and substance abuse issues.

The following goal and strategies address the mental health barriers:

GOAL 1:

Improve continuity of care and access to mental health services.

Strategy 1: Consider feasibility to expand services (outpatient) to the Brunswick area.

Strategy 2: Develop informational programs to provide education to children and parents in local school systems.

Strategy 3: Explore the possibility of developing a peer support worker program.

Strategy 4: Continue to explore the possibility of a formal partnership with a community mental health agency.

Substance Abuse

In addition to the growing behavioral health problems across the study area, there is an increased use of drugs and alcohol. Substance abuse is often associated with mental health illness. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported in their 2013 National Drug Use and Health Survey that 24.6 million residents 12 years or older were current illicit drug users.[30] Marijuana is the most commonly used drug in the U.S. with 19.8

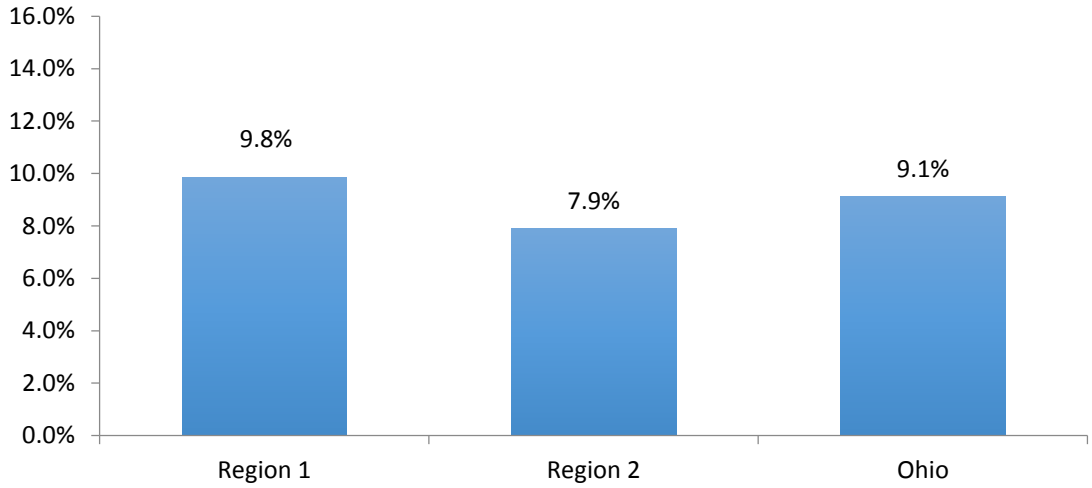
[29] (Source: 2014, the National Institute of Mental Health

[30] The Substance Abuse and Mental Health Services Administration: www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm

million users in 2013 compared to 14.5 million in 2007.[31] In addition, more than one-half of Americans aged 12 or older were current alcohol users in 2013.[32] In 2013, 22.7 million individuals aged 12 or older needed treatment for an illicit drug or alcohol problem; however, only 2.5 million received treatment in a specialty facility.[33]

According to the NSDUH Substate Estimates of Substance Abuse and Mental Disorders, illicit drugs include: marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically (See Figure 7).

Figure 7: Illicit Drug Use in Past Month (from 2010-2012 survey)



- Region 1: Includes Cuyahoga and Lorain County
- Region 2: Includes Medina

Source: NSDUH Substate Estimates of Substance Abuse and Mental Disorders

Access to care for those seeking and needing behavioral and mental health services and programs is further hindered by a shortage of mental health providers and inadequate insurance coverage. The demand for behavioral health services will continue to grow, specifically in Lorain and Medina counties[34]. Both the 2012 and the 2016 CHNA studies highlight the need for additional mental health and substance abuse services and programs.

A significant spike in the use of opioids and unintentional overdose due to opioid abuse has occurred over the past few years. Unintentional overdoses due to all types of opioids reached a

[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Truven Health Analytics projects Lorain County growing by 1.5% and Medina projected to grow by 2.4% in years 2016-2021.

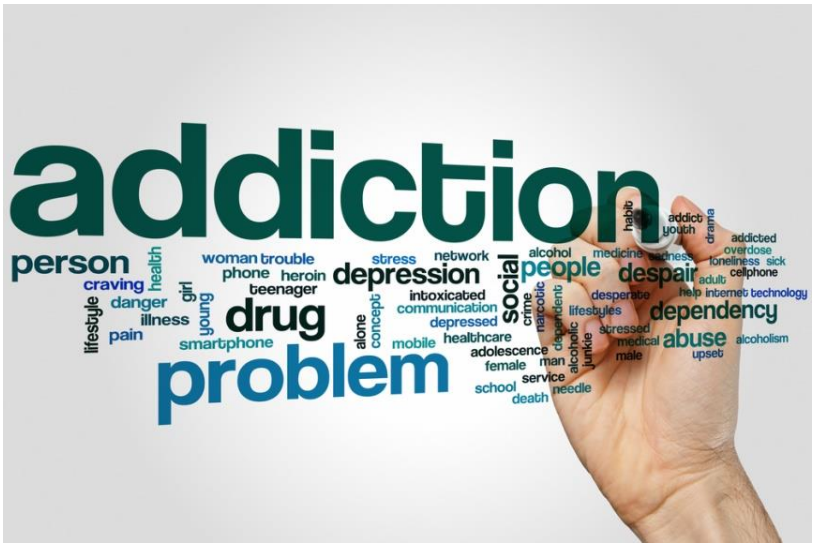
high of 2,020 deaths in 2014, accounting for 79.8 percent of all unintentional types of poisoning deaths. Broad awareness and education arms medical staff and the community with vital information and resources that help providers better understand adverse effects of prescription drug/opioid use and misuse. Awareness and education improves their assistance in providing proper care, treatment and the prevention of opioid related deaths.

While marijuana is the most commonly used drug, it was also reported that more than one-half of Americans aged 12 or older were current alcohol users in 2013. With a growing incidence of high risk behaviors and substance use among school age youth, educational services and programs are designed to prevent substance use, and for the early detection and treatment of substance use among youth.

The world can be a dark and lonely place for teens who live in an unstable home environment or who are victims of bullying. Many numb the emotional pain with alcohol or other drugs. In many cases they can become addicted to those substances, says Kristin Fox, a licensed independent social worker and manager of outpatient programs for Southwest General's Oakview Behavioral Health services.

According to Kristin Fox, without help, addicted adolescents can become addicted adults, who could end up in jail or even worse, but Kristen warns it does not have to happen. “Oakview Behavioral Health offers a variety of adolescent mental health and addiction programs to help those kids,” she says. “Our counselors are especially trained to work with youth, and they all have backgrounds in mental health issues.”

Cited from a former patient from Oakview Behavioral Health services, “I personally can't say enough about Oakview. I have been sober since January 10, 2013. The program gave me the tools to build a solid foundation of sobriety. No road to sobriety is easy but with the right guidance I am now able to work at becoming the person I'm meant to be. Today I’m a student at Cleveland State University pursuing a degree in psychology with the goal of becoming a counselor one day. Also, I am happy to say that the hopeless and helplessness feeling that once plagued me have now been replaced with ambition and happiness. None of this would have been possible



without the counselors in the adolescent addiction recovery program." [35]

The following goal and strategies address substance abuse barriers:

GOAL 2:

Improve access to programs and services for patients who seek and need substance abuse assistance.

Strategy 1: Expand medical staff and broad community awareness and education to impact prescription drug/opioid misuse, abuse and opioid-related deaths.

Strategy 2: Provide educational prevention services and programs to residents with special focus on school systems.

Strategy 3: Explore the feasibility of expanding outpatient treatment services for drug-addicted patients.

Treatment services to address chemical dependency are provided through an emergency intake and assessment team positioned in the ED, the Intensive Outpatient Program (IOP) for adults and for adolescents, and ambulatory/outpatient care provided by the psychiatrists. An expansion of out-patient substance abuse services will strengthen access to care for individuals and families, improve the continuity of their care and reduce the unnecessary use of hospital emergency departments, community resources and shelters.

Next Steps/Moving Forward

This CHNA Implementation Strategy is the "how" Southwest General will leverage its strengths, resources, community outreach programs, and partnerships with community organizations to address the community health needs identified in the 2016 CHNA. The CHNA Implementation Strategy builds on the input from diverse community leaders, providers and individuals and delineates measurable goals, strategies, and metrics designed to impact the overall health and well-being of community residents.

The implementation phase provides a platform for continuing solid relationships with community and national partners and developing new community relationships that will strengthen the ability to address health needs. Throughout the implementation phase,

[35] The Dark Truth; Southwest Today 2015

Southwest General will consistently track the achievement of goals and strategies, evaluate success in meeting identified community health needs, and broadly communicate progress to the communities Southwest General Health Center serves.